COMPREHENSIVE HEALTH EDUCATION IMPLEMENTATION PLAN

A GROUNDING DOCUMENT FOR SCHOOL ADMINISTRATORS AND EDUCATORS

Health & Physical
EDUCATION

Letter to the Reader

To begin, the Health Education team wishes to address a few key components necessary to understanding who we are and what influences our work.

First, while the Health Education team is aware of the shortcomings of a land acknowledgment, we also recognize the importance of naming the original stewards of the land in which Portland Public Schools and its district buildings reside. Therefore, we want to acknowledge the land on which our team (along with many others) lives, works, plays, and raises families. The Portland Metro area was seized from the Indigenous tribes of the Multnomah, Wasco, Cowlitz, Kathlamet, Clackamas, Bands of Chinook, Tualatin, Kalapuya, Molalla, and many other tribes who made their homes along the Columbia River. We wish to thank the original caretakers of these lands and pay our respects to their elders - past, present, and future.

Second, we want to acknowledge the significant privilege our team holds. This is by no means an exhaustive list, but a majority of the members on this team are white, educated, cis, able-bodied, English-speaking women. Outside of this majority, a few team members are women of color who also hold some of the above-mentioned identities as well as those not listed. Naming and recognizing these identities must be done for several reasons. First, this is to inform readers of our team's perspectives and lived experiences along with the valuable perspectives and lived experiences that are missing.

Additionally, health education is grounded in social justice. Therefore, our team must be critical of the external influences and systems that affect health, both at the individual and community level, and work towards dismantling long-held systems of oppression so that all of our students may live long, happy, and healthy lives. This work cannot be done without first looking at ourselves and examining how some of us have benefited from these systems of oppression and how our power and privilege may reinforce these systems and affect others. Finally, by growing up and living in a Eurocentric society built upon the oppression of others, we also know that there may be implicit and unconscious biases at work. We wish to state all of this in alignment with the team's values around honesty, transparency, and a commitment to recognizing our biases which may consciously or unconsciously influence our work and relationships with students, teachers, parents, and colleagues.

On a final note, we wish for the reader to understand that every member of this team is dedicated and devoted to ongoing social justice and equity work; utilizing an intersectional lens; creating inclusive, culturally responsive, trauma-informed curricula; and reducing the harm that school health education has caused too many oppressed and marginalized groups in years past. We recognize that we are not the sole keepers of health education within Portland Public Schools. The lived experiences of our students, parents, teachers, and colleagues are invaluable to shaping the future of our health education curricula and materials. At any time, we are open to honest and constructive feedback, which helps to make our teaching

materials better, and ultimately provides a more informative and impactful educational experience for our students. If you have any feedback you wish to share, please go here.

Respectfully,
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Introduction

School health education programs got their footing thanks to Lemuel Shattuck and his groundbreaking 1850 report for the Sanitary Commission of Massachusetts.[19] In this report, Shattuck explains,

> *"Every child should be taught early in life that, to preserve his own life and his own health and the lives and health of others, is one of the most important and constantly abiding duties... By knowing and avoiding the causes of disease, disease itself will be avoided, and he may enjoy health and live; by ignorance of these causes and exposure to them, he may contract disease, ruin his health, and die. Everything connected with wealth, happiness and long life depends upon health..."*[3]

Nearly two centuries later, Shattuck's words still reign true for our hopes and wishes for every student within Portland Public Schools (PPS). As our society continues to learn more about health, its direct and indirect causes, PPS understands the importance of starting health education from a young age. Through the Health Education team, PPS hopes to positively influence the health literacy of our students, their families, and the communities in which we live, work, and play.

In 2020, the US Department of Health and Human Services updated their definition of *health literacy* and separated it into two main categories.[37] Introduced in the *Healthy People 2030* initiative, health literacy is defined as:

- "**Personal health literacy** is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.
- **Organizational health literacy** is the degree to which organizations equitably enable individuals to find, understand, and use information and services to inform health-related decisions and actions for themselves and others."[37]

Both facets are critical components of health education in PPS, as our students' access to personal health literacy is dependent upon our organizational health literacy. To foster students' personal health literacy, PPS has embedded it within the graduate portrait, through characteristics such as developing powerful and effective communicators, inclusive and collaborative problem solvers, and transformative racial equity leaders.[29] Additionally, the Health Education team specifically works to provide curricula and instructional materials/resources, professional development opportunities, and other technical assistance to over 1,500 K-12 teachers who teach health. The Health Education team understands the crucial position and importance teachers hold when fostering personal health literacy in their students and want to do whatever they can to ensure students have equitable access to quality health education across the district.

The importance of health literacy can not be understated as many studies suggest that low health literacy is associated with poorer health outcomes.[24,38] In addition, having low health literacy can perpetuate health inequities as it is more prevalent among oppressed and marginalized populations due to racism, sexism, cisgenderism, ableism, classism, heterosexism, and other systems of oppression.[24,38] Ultimately, these inequities are reflected in differences in quality of life, rates and severity of disease, access to treatment, disability, and death.[20] However, robust health education that bolsters one's personal health literacy has the power to reduce these inequities.[24,38] Therefore, ensuring that all students have high health literacy skills by the time they graduate from PPS, as well as the skills needed to communicate, inform, and advocate for others can help bring our communities one step closer to reducing health inequities.

Understanding all of this, in March 2021, the PPS Board of Education unanimously passed the Comprehensive Health Education Policy 6.40.013-P, replacing the Comprehensive Sexuality Education Policy with a more well-rounded approach to school-based health education. This new policy formalizes the requirement that every year "students in grades K through 12 be taught Comprehensive Health Education that is medically-accurate, age and developmentally appropriate, culturally and linguistically sustaining, and implemented in safe and supportive learning environments where all students feel valued."(p. 1).[30]

This document strives to complement this new policy. It is intended to provide district staff, school administrators, and educators, both new and experienced, with an overview of health education requirements across the state along with the Health Education team's recommendations for teaching health

education within PPS. Throughout this guide, we hope for readers to understand (or be refreshed on):

- The laws and policies that shape the landscape of health education in Oregon.
- The Oregon Health Education Content Standards and Performance Indicators.
- The importance of using a skills-based health education approach.
- Best practices when teaching the various health education subjects.
- Suggested curricula, materials, and other learning resources vetted through the Health Education team, community-based organizations, PPS teachers, and students.

Laws & Policies

There are many laws and policies at the federal, state, and local levels that the health education curriculum must comply with at PPS. The table below contains the various statutes and PPS-specific policies that influence the health content areas in our scope and sequence, as well as the curricula and teaching materials that the Health Education team suggests all K-12 health educators use. To learn more about each of these laws and policies, please click on the links in the chart below.

Comprehensive Health Education (General)	Wellness	Mental & Emotional Health	Alcohol, Tobacco, & Other Drugs	Growth & Development/Violence Prevention	PPS-Specific Related Policies
• OAR 581-022-2000: Diploma Requirements • OAR 581-022-2030: District Curriculum • OAR 581-022-2310: Equal Educational Opportunities • OAR 581-022-2312: All Students Belong • OAR 581-029-0001: School Safety and Prevention System	• ORS 336.472 (SB 79): Cardiopulmonary Resuscitation • HB 2969: Oral Health	• OAR 581-022-2060: Comprehensive Guidance and Counseling • OAR 581-022-2510 (Adi's Act, SB 52): Suicide Prevention • ORS 339.351-364: Harassment, Bullying, Cyberbullying, and Intimidation	• OAR 581-022-2045: Prevention Education in Drugs and Alcohol • ORS 336.222: Alcohol Tobacco and Other Drugs. • ORS 336.241: Cannabis Abuse Prevention	• Title IX: Title IX of the Education Amendments Act • OAR 581-022-2050: Human Sexuality Education • ORS 174.1: Oregon Equality Act • ORS 336.035: Required Courses of Study • ORS 336.059 (Erin's Law, SB 856): Child Sexual Abuse Prevention Instruction • ORS 336.455: Human Sexuality Education, K-12. • ORS 336.465: Examination of Instructional Materials • ORS 339.366 (Healthy Teens Relationship Act, HB 4077, SB 790): Teen Dating Violence and Domestic Violence	• 1.80.020-P: Non-discrimination/Anti-Harassment • 2.10.010-P: Racial Educational Equity Policy. • 3.60.062-AD: Student Wellness through Nutrition and Physical Activity. • 3.30.021-P: Tobacco Possession & Use • 4.30.050-P: Student Suicide Prevention • 4.30.060-P: Anti-Harassment. • 4.30.061-AD: Transgender, Nonbinary, and Gender Diverse Students • 4.30.071-AD: Harassment, Sexual Violence, and Teen Dating Violence • 4.30.072-AD: Title IX Student to Student Sex-Based Discrimination and Harassment.

Standards, Performance Indicators, & Skills-Based Health Education

Aside from laws and policies, three significant components shape health education in PPS, Oregon Health Education Content Standards, Performance Indicators, and Skills-Based Health Education. The **Oregon Health Education Content Standards** **(OHES**) help define the knowledge and skills students will need throughout their K-12 experience. These standards also provide consistency in what is taught to students across our state to ensure equity in education. They were developed to establish, promote, and support positive health behaviors among students in grades K-12. The standards provide a framework for teachers, administrators, and policymakers in designing and selecting curricula, allocating instructional resources, and assessing student achievement and progress. Notably, the standards provide students, families, and communities with concrete expectations for health education. There are eight primary standards of Health Education which are divided into two categories: Content and Skills. **Standard One** focuses on knowledge - teaching students the information (content) they need in order to engage in health promotion and disease prevention. Standards two through eight focus on a variety of skills necessary for students to enhance their own health, and the health of their communities.

The skills targeted in Standards Two through Eight include

- **Standard Two:** Analyzing the influence of family, peers, culture, media, and technology on a student's health behaviors.
- **Standard Three:** Teaching students how to access valid and reliable health information.
- **Standard Four:** Building each student's interpersonal communication skills.
- **Standard Five:** Enhancing student decision-making skills.
- **Standard Six*:*** Practicing goal-setting to enhance health and avoid risks.
- ***Standard Seven:*** Supporting the engagement in self-management and personal responsibility.
- **Standard Eight:** Empowering students to advocate for their personal, family, and community health.

The OHES are intentionally broad in nature because they are an ultimate goal for students. Each standard is broken down into smaller actions and skills that educators can assess; these are called **Performance Indicators (PI)**. Despite the OHES Standards remaining the same from grade to grade, the PIs become more complex as students advance in their skills and complete each grade. In the upper grades, specific standards can have upwards of 50 PIs; therefore, it is not required that students be summatively assessed on all of them. This is due to, in part, the time constraints of the school

day and time allotted to health education. Additionally, the PIs are intentionally scaffolded across grades K-12, therefore even if a PI isn't summatively assessed, students may still be learning and meeting the PI. Below is an example of how to read the OHES and how the PIs are linked to them.

Standard 7. Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

HE.7.3.1 Recognize responsible personal health behaviors.
HE.7.3.2 Recognize a variety of healthy practices and behaviors that maintain or improve personal health.
HE.7.3.3 Recognize a variety of behaviors to avoid or reduce health risks.
HE.7.3.4 List ways to treat yourself and others with dignity and respect, with regard to race, ability, other identities, gender, gender identity, and sexual orientation.

KEY

HE. - Indicates the **content area**, which in this case is health education.
.7. - Indicates which **OHES standard** the PIs are linked to. This would be for Standard 7.
.3. - Indicates which **grade level** these PIs are intended. This would be for grade 3.
.4. - Helps to **identify each specific PIs.** This would be the fourth PI.

The final component shaping the curricula and other teaching materials provided to teachers is **Skills-Based Health Education (SBHE)**. Defined by the World Health Organization, SBHE is "...an approach to creating or maintaining healthy lifestyles and conditions through the development of knowledge, attitudes, and especially skills, using a variety of learning experiences, with an emphasis on participatory methods." (p. 3).[41] Complementing the OHES content, there are seven skills that each PPS student should develop and hone throughout their academic career. RMC Health defines the seven skills as: [31]

Analyze Influences	"Focuses on identifying and understanding the diverse internal and external factors that affect health practices and behaviors."
Access Valid & Reliable Resources	"Prepares students to be able to critically evaluate the health information around them, whether that is from research articles, advertisements, people, and other print materials."
Interpersonal Communication	"Guides students to better understand, practice, and reflect on their interactions with others, develop effective speaking and listening strategies, boundary setting/refusal skills, conflict resolution skills, and collaboration skills."
Decision Making	"Decision making provides students with a process to approach decisions related to their health that require more thought and intention."
Goal Setting	"Empowers students to strive for self- improvement by creating short and long term goals that have clear plans to help with follow through."
Self Management	"Helps students identify the areas in their life where they must take personal responsibility and develop the necessary health practices to maintain and improve their health.
Advocacy	"Helps students build the capacity to promote their healthy behaviors and to encourage their peers to develop and maintain their own healthy behaviors."

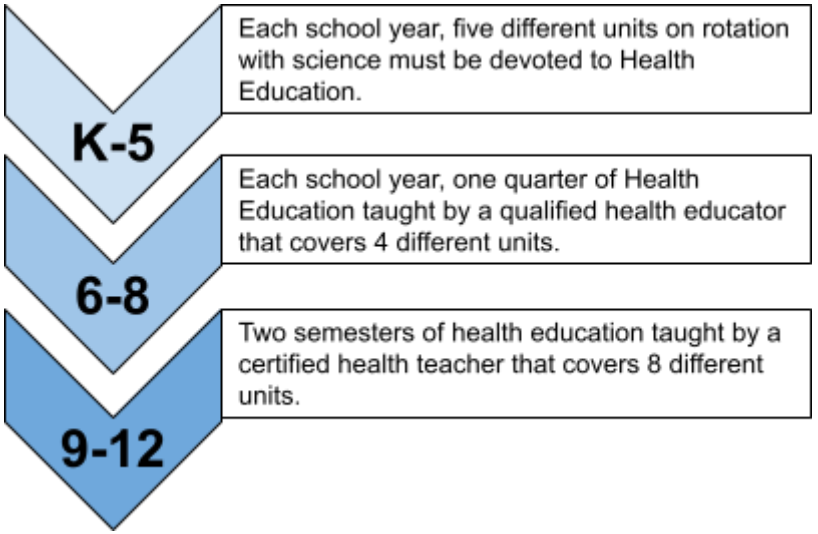
Transitioning from a traditional content-based approach to skills-based health education allows students to develop and practice the skills they will need to maintain a healthy life. This approach can help students make healthy choices, prevent engagement in harmful health behaviors, and ultimately help them develop the self-efficacy to maintain these behaviors across their lifetimes.[41] Additionally, providing students with the time to enhance their skills in a low-stakes, controlled environment (such as the classroom), can help them feel more confident when applying them in situations that arise outside of school.[41]

The scope and sequence provide educators with a planned progression of the health units. While the health education skills complement each other and can be applied to any health unit within the scope and sequence, only **one to two** health skills are paired with each health unit to best support the growth development of youth and is formally assessed within each unit.

For example, at the high school level, the skill paired with the Comprehensive Sex Education unit is Decision Making. Therefore, although all of the Health Education skills are covered during the unit, the only formal assessment is used to determine how well students have applied their knowledge of the topic through the decision-making process. A full breakdown of unit topics, health skills, and lesson pacing can be found here.

Health Topics & Units

Following PPS policy, 6.40.013-P, all schools will follow the relevant promotion and graduation requirements that include:



Additionally, all students in grades K-12 **must** receive at least **four** lessons in child sexual abuse prevention (ORS 336.059/SB 856) **each year**. These are the minimum requirements for health education programming, including comprehensive sexuality education (CSE). In addition, health education (inclusive of CSE) will be integrated into the Common Core curricula where possible. The rest of this document will provide an overview of the health units taught across the K-12 PPS scope and sequence.

Comprehensive Health Education addresses several topics, including alcohol, tobacco, and other drug use/abuse prevention; healthy eating/nutrition; mental and emotional health; personal health and wellness; safety and injury prevention; violence prevention; and comprehensive sexual health education. Within each topic area, students will be taught an overview of the topic along with its health effects, the skills associated with the unit at the various grade levels, and tips, suggestions, and examples for instruction. In addition to this document, there is an additional Resource Hub to help teachers learn more about a topic area or to use within their lessons. This document is broken down by topic area, highlighting the health skills paired with each unit, and provides a small description of the resource. If there is a valuable resource that we missed that you'd like to add, or if a link is broken, please feel free to let us know here.

Best Practices in Health Education

Health Education is a broad subject area covering a variety of topics, each with its own particular nuances. However, there are some general best practices that can be applied across all of the units. While this is not an exhaustive list, the following are some tips and best practices when teaching health education in your classroom.[34]

- Create and maintain a positive learning environment in which *all* students feel emotionally, socially, and physically safe. In addition, this environment should be inclusive and supportive of all students, regardless of race, ethnic origin, gender identity, sexual orientation, religion, or physical ability. For examples on where to start, read more here.
- All students are acknowledged, appreciated, valued, and respected.
- Classrooms are to be designed in such a way that learners feel engaged and have a sense of ownership within the space.
- Teachers should collaborate with other school services (e.g. nutrition services, school social workers, etc.) to enhance the classroom and school environment in supporting healthy behaviors.
- Health education lessons and instruction are focused on the achievement of learning objectives and skill development with formative assessments to monitor progress.
- Lessons and instruction are trauma-informed, culturally sensitive/responsive, medically accurate, and age-appropriate.
- Lessons and instruction include instructional strategies that promote student self-reflection and help students personalize the lessons.

- Activities and materials need to be current, up to date, and relevant to students which include participatory teaching and cooperative learning styles.
- Health education teachers should differentiate instruction to meet the needs of all learners and use different modes of delivery and a variety of approaches to engage all students.
- Teachers should be prepared to adjust instruction during lessons, as necessary, to meet the needs of all learners.
- Teachers should engage in professional development activities to keep up-to-date with changes in the field.

General Wellness

The COVID-19 pandemic shone a spotlight on our need to understand how people become infected and sick with viruses and diseases. Focused primarily within grades K-5, the Wellness Unit helps students learn about what it means to be healthy, what germs, viruses, and diseases are, how they are transmitted and how to avoid them, and what to do when people become sick. This focus on disease prevention and personal wellness/hygiene in our students' early years of health education is important so they can begin to create habits that will keep them healthy and prevent illnesses from spreading to their classmates and loved ones.

The following diagram provides a quick snap-shot of how the skills align within the General Wellness Unit for each grade level. For a more detailed understanding of the suggested materials, unit order, and lesson pacing, click here to access the Health at a Glance.

Alcohol, Tobacco, and Other Drugs

From public health campaigns about drunk driving to scare tactic ads such as an egg on a frying pan with the simple tagline line of "This is your brain on drugs," Alcohol, Tobacco, and Other Drugs (ATOD) education and prevention efforts have been around for decades. Results from the 2019 Youth Risk Behavior Survey (YRBS) indicate that across the nation, approximately 30% of high school students reported current alcohol use, 22% reported current marijuana use, 14% reported current binge drinking, and 8% reported current prescription opioid misuse.[31] In Oregon, approximately one-third of students report current use of alcohol and marijuana while cigarette smoking, cigar-smoking, and smokeless tobacco use decreased among high school students.[31] Still, the increased prevalence of electronic vapor products among youth is concerning. Usage of electronic vaping products increased by a third across the nation, from 24.1% in 2015 to 32.7% in 2019, and within PPS, almost half of students (41%) have used an electronic vaping product.[16,31]

ATOD use, misuse, and abuse can profoundly affect many essential aspects of an individual's life, including mental, emotional, social, physical, and spiritual health and school and/or work success. Long-term or chronic substance use can affect a person's nutrition, sleep, decision-making ability, and impulsivity.[26] It is associated with increased risk for trauma, violence, injury, behavior problems, academic under-performance, infectious diseases, higher heart rate, higher blood pressure, heart attack, stroke, mental health illnesses, overdose, and even death.[26] Studies show that the earlier teens start using alcohol, tobacco, and other drugs, the greater their chances of using substances and developing substance use problems later in life.[9] Therefore, education at the school level is critical to reducing problems that arise from ATOD misuse and abuse.

When teaching about substance use prevention, solely relying on scare tactics such as mock car crashes, stories by former drug abusers, graphic images of people using drugs, etc., are not effective and should be avoided (like the "Every 15 Minutes" program). This is because scare tactics emphasize the worst dangers of drug use in order to create fear and anxiety, in hopes that the fear alone will prevent or stop risky behaviors.[27] Additionally, relying on scare tactics is not a student-centered approach and may cause harm to students due to the at-home situations they may be facing with caregivers or loved ones or previous trauma they have experienced.

Regardless of the grade level, ATOD education and prevention is meant to show that the use of alcohol, tobacco, and other drugs is not the norm for most students in K-12 settings.[2] Furthermore, it should help students to focus on how the media influences our thoughts and ideas about these substances. Additionally, lessons can emphasize developing students' social and emotional skills to help them handle potentially difficult social situations, cope with change, manage stress and other emotions, and learn from setbacks. Finally, these lessons ought to inform students of the risks and short- and long-term outcomes of alcohol, tobacco, and other drug use, and bolster their refusal skills while still maintaining their friendships (if they so choose).

The following diagram provides a quick snap-shot of how the skills align within the ATOD unit for each grade level. For a more detailed understanding of the suggested materials, unit order, and lesson pacing, click here to access the Health at a Glance.

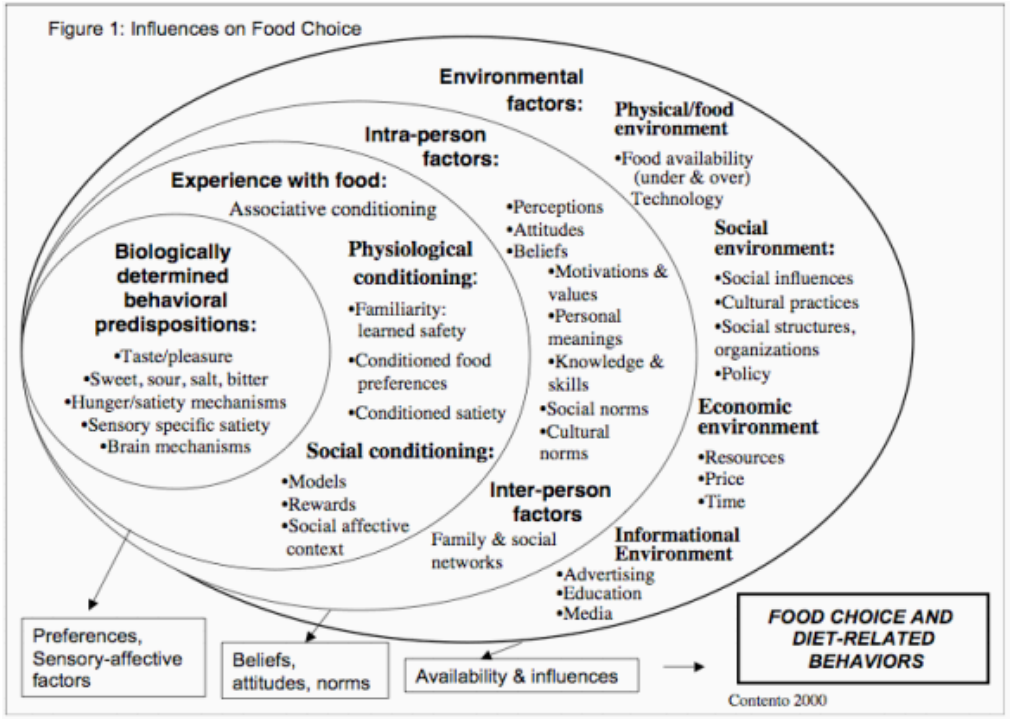
Nutrition

Many of our dietary habits are formed during our childhood and follow us throughout our lives. Therefore, it is important for students to be knowledgeable about food and nutrition at an early age. Nutrition education can be defined as, "...any combination of educational strategies, accompanied by environmental supports, designed to facilitate voluntary

adoption of food choices and other food and nutrition-related behaviors conducive to health and well-being…"[25]

Healthy nutrition and eating habits are important to developing and maintaining physical strength and cognitive abilities. Eating a balanced diet can help students nourish their growing minds and bodies and reduce the risk of developing chronic health illnesses such as heart disease, high blood pressure, iron deficiencies, and more.[10] When students do not have access to nutritionally dense food, they may have lower grades than their peers and may be at higher risk of developing many of the chronic illnesses mentioned above.[11]

It would be opaque to not identify the many pitfalls of nutrition education in the US. First, it is important to note that what influences a student's access and ability to consume food is often dictated by many factors outside of their control. Students and their family's access to certain types of food are often directly influenced by their built environment. As more attention has been brought to food-insecure neighborhoods (which disproportionately affect communities of color), they have been coined, *food deserts.*[7,33] This term however is problematic as it diminishes the vibrancy and natural occurrence of deserts themselves.[7,33] A more apt name when describing this phenomenon would be, *food apartheid*, which takes into account the larger social systems of oppression and root causes that allow for certain areas to be limited in their food choices or where there is no access to a grocery store.[33] The following figure shows just how multi-faceted our food choices can be.



Source: Contento, I.R. (2007) Nutrition education: linking research, theory, and practice

As students may be living in areas without access to grocery stores, simply teaching students the knowledge and mechanics behind food (e.g. the different food groups, a breakdown of macro and micronutrients, etc.) may not be applicable to students and helping to inform their dietary behaviors. In addition to influences outside of students' control, nutrition education which promotes the proliferation of a "standardized diet" from governmental organizations (e.g. MyPlate) lacks cultural sensitivity and curtails the lived

experiences of youth whose families cook traditional, non-Western, and/or non-American meals.

Furthermore, with the explosion of social media, photoshop, and a society obsessed with thinness and anti-fat biases, this long-held approach of nutrition education with a focus on the caloric value of food, understanding of macro/micronutrients, and demonization of certain categories of foods may be seriously activating for students who have dealt with (or are currently dealing with) disordered eating or an eating disorder. The need for culturally responsive and trauma-informed lessons around nutrition is vital. Recent data shows that starting as young as elementary school, children desire to be thinner and are “afraid of being fat.”[4,5] Moreover, by the time students reach adolescence, approximately 6%-10% of students will have an eating disorder. [4,5,20]

The Health Education team is aware of the aforementioned pitfalls and current state of nutrition education in the U.S., and in our current lessons. We are committed to creating more culturally responsive and trauma-informed lessons for our students. During the 2020-2021 school year, the Health Education team was approached by several PPS students and began a dialogue on how to make these lessons better. We are working toward integrating these changes and will continue to work with students, teachers, and parents in years to come. Additionally, in the summer of 2021, the Health Education team was awarded a grant to help bolster and revamp the Nutrition lessons in grades K-5. These lessons will be developed in partnership with culturally specific CBO’s and will be rolled out for the 2023-2024 school year.

In the meantime, teachers and administrators are encouraged to first look at themselves and question their attitudes and beliefs about nutrition and food. Students are always listening and absorbing what is being said in classrooms and the hallways. Comments around things such as the moralization of food (e.g. “junk food”, “cheat meals”, “clean food”, etc.) can negatively impact students. Additionally, while it is also important and encouraged for teachers to adapt the lessons provided by the Health Education team and tailor them to your classroom; during this unit, it may be even more vital depending on the make-up of your students.

The following diagram provides a quick snap-shot of how the skills align within the Nutrition unit for each grade level. For a more detailed understanding of the suggested materials, unit order, and lesson pacing, click here to access the Health at a Glance.

Mental & Emotional Health

Content Warning (CW): Discussion of poor mental health and suicide.

Defined by the Collaborative for Academic, Social, and Emotional Learning (CASEL) organization, social and emotional learning (SEL) “...is the process through which all

young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions."[8]

Oftentimes, mental, behavioral, and developmental disorders begin in early childhood. According to the CDC, 1 in 6 U.S. children aged 2–8 years (17.4%) have a diagnosed mental, behavioral, and/or developmental disorder.[13] Mental health conditions, such as depression and anxiety, often occur simultaneously and the prevalence of these conditions typically increase as students become older.[13] At its extreme, poor mental health has been associated with increased risk for non-fatal (e.g. suicidal ideations or attempts) and fatal (e.g. suicide) suicidal behaviors. After unintentional injuries, suicide is the second leading cause of death among high school youth ages 14-18.[22] Before the COVID-19 pandemic, over one-third (34%) of PPS high school students reported feeling sad or hopeless almost every day for two or more weeks to the point it interfered with some of their daily activities.[32] Furthermore, in the 12 months prior to the survey:

- 1 in 6 students made a plan about how they would attempt suicide.
- 1 in 17 students attempted suicide.
- 1 in 40 students had a suicide attempt that resulted in an injury that had to be treated by a medical provider.

These statistics are startling enough, but when the data is separated out by demographics, such as sexual orientation, sex, and race, these rates are significantly more prevalent amongst minority communities. Altogether, this provides a clear and strong case for the need for mental, social, and emotional health lessons in our curriculum. Studies suggest that through social, mental, and emotional education, there are:

- More positive attitudes toward oneself, others, and tasks including enhanced self-efficacy, confidence, persistence, empathy, connection, and commitment to school, and a sense of purpose.
- A decline in students' anxiety, behavioral problems, risk-taking health behaviors such as substance use, sexual activity, etc.
- Improvement in students' social and emotional skills, attitudes, relationships, academic performance, and perceptions of classroom and school climate.[39]

These improvements in students' mental, social, and emotional health are achieved through the development of the five main competencies - *self-awareness, self-management,*

social awareness, relationship skills, and responsible decision-making.[8] In accordance with CASEL, effective instruction in this unit should follow the acronym **SAFE**.[39] This stands for

- **Sequenced** - following a coordinated set of training approaches to foster the development of competencies.
- **Active** - emphasizing active forms of learning to help students practice and master new skills.
- **Focused** - implementing a curriculum that intentionally emphasizes the development of SEL competencies.
- **Explicit** - defining and targeting specific skills, attitudes, and knowledge.[39]

Additionally, it is well documented that students who are racial minorities or identify as a gender or sexual minorities (LGBTQIAA2S+) have poorer mental health outcomes than their white, cisgender, and/or heterosexual peers.[22, 31] Of course, a racial minority or LGBTQ+ identity is not a causative factor for these health disparities, but rather, a reminder of how harmful systems of oppression can be on a person's health. Therefore, it is vital to ensure that one's classroom and school are safe and supportive for all students. Importantly, microaggressions committed by other students such as incorrect pronoun usages, racial slurs, name-calling, etc. ought to be immediately interrupted and stopped. If you are unsure where to start when creating a safe and supportive environment for students, the following is an example from the Oakland Unified School District in California for integrating some of these strategies into one's classroom (see Diagram 1)

Below is a quick snap-shot of how the skills align within the Mental and Emotional Health unit for each grade level. For a more detailed understanding of the suggested materials, unit order, and lesson pacing, click here to access the Health at a Glance.

Violence Prevention

CW: Mentionings of physical violence, sexual assault, rape, and bullying.

Every student has the inalienable right to learn and play in safe and supported environments. Unfortunately, the surveyed and documented reality of students' encounters with interpersonal violence indicates that there is still a long way to go before this can become a reality. Interpersonal violence is defined as aggression committed by another person and encompasses dating violence, sexual violence, and bullying.[6] Traumatic events such as being the victim of interpersonal violence during childhood or adolescence can be viewed as adverse childhood experiences (ACEs), which are associated with various negative health outcomes and behaviors.[6] These include higher levels of adverse mental health symptoms and illnesses (e.g., depression, anxiety, ADHD, etc.), substance

abuse, engaging in riskier sexual behaviors (e.g., lack of condom use, multiple partners, lower rates of testing, etc.), in addition to lower levels of fruit and vegetable consumption, and poor sleeping hygiene.[12,28]

The regrettable reality is that across the U.S., approximately one in eight students reported experiencing dating violence, and one in four reported bullying victimization.[6] According to the 2019 YRBS survey conducted in PPS, these statistics hold true for our students as well.[31] What is also troubling is that almost one in ten high school students surveyed in PPS indicated that they were physically forced to have sexual intercourse (when they did not want to) which is nearly two percentage points higher than the national average.[6,31] Together, this illustrates that the need for violence prevention lessons is more timely, pressing, and relevant than ever.[31]

Due to the sensitive nature of this topic, it is important to place this unit towards the end of the school year and/or your allotted time with students. This allows for classroom rapport and connectedness between students and their peers, as well as students-teacher trusted relationships to be built throughout the previous weeks or months. Also, it's important for teachers and administrators to become familiar and more comfortable with this topic. As stated earlier, it is mandatory for students to receive a minimum of four lessons each year about violence prevention in accordance with Erin's Law (SB 856). By becoming more familiar with this topic (e.g. attending professional development training), administrators and teachers can learn the skills necessary to teach about these subjects in a trauma-informed way and potentially mitigate any further harm that may be incurred while learning about violence prevention. Finally, it is important to provide students with content warnings (CW; like the one shown above), so that students can excuse themselves and avoid potentially activating lessons and materials. In addition, be sure to work with any student if they need to be excused from a lesson and use an opt-out or alternative lesson to make up for any missed homework, assessments, and/or skill development.

The following diagram provides a quick snap-shot of how the skills align within the Violence Prevention unit for each grade level. For a more detailed understanding of the suggested materials, unit order, and lesson pacing, click here to access the Health at a Glance.

Comprehensive Sexuality Education

The core belief of comprehensive sexuality education (CSE) is that youth have a fundamental right to receive medically accurate, culturally inclusive, and trauma-informed information regarding their sexual and reproductive health.[1] One framework of sexuality education is abstinence-only programs which use scare tactics to promote chastity and self-discipline by championing that abstinence is the best option for teenagers who wish to engage in any sexual activity outside of marriage. In contrast, however, CSE utilizes an

approach that states abstinence is the most effective method for avoiding and destigmatizing sexually transmitted infections (STIs) and unintended pregnancy, but also provides education on the most commonly used contraceptive methods, human development, personal skills (such as communication and decision-making skills), healthy relationships, and the impact of societal/cultural influences of health decisions.[1]

According to the national 2019 YRBS survey, close to one-third of high school students (27.4%) reported being sexually active.[31] Within PPS, this rate is lower, but still, about one in five high school students report currently being sexually active. Of those who are currently sexually active, a little over half (56%) utilized a condom and only about one in eight (13%) were tested for an STI and/or HIV.[31] Research shows that effective CSE leads to health-enhancing behaviors such as a delay in the initiation and frequency of sexual activity, reduces the number of new partners, and increases the correct use of barrier and contraception methods.[1,36]

Over the past decade, Oregon became a pioneer in strengthening state policies to ensure all Oregon youth have access to CSE. In 2015, the Oregon Department of Education approved OAR Rule 581-002-2050 which requires all public school districts to develop both an educational policy and a plan to teach comprehensive human sexuality in schools. The first comprehensive sexuality education plan (CSEP) was completed in July 2018 through the collaborative efforts of PPS K-12 teachers, administrators, community partners, and government officials. To review the most recent CSEP, click here.

When teaching this unit, it's important to be aware of how our biases (i.e. racial, cisgender, heteronormative, socioeconomic, ableist, and more) may influence these lessons and instruction. Historically, youth of color, particularly young girls of color, are disproportionately stereotyped as the "bad girl," in contrast to young white girls who are typically portrayed as "morally correct" and "innocent" in sexuality education curricula.[14,18,21] Moreover, African American and Latinx girls are often represented as hypersexualized beings and the protagonist in many teenage pregnancy cautionary tales.[14,18] Boys of color, and particularly African American boys, are portrayed as aggressive or lacking control and being sexually corrupting, whereas stereotypes about "Latino culture" and machismo attitudes linked Latine boys to being reproductive abusers and stereotypically not using condoms when engaging in sexual activities.[14,18] Furthermore, excluding LGBTQIA2S+ students sends the message that these students are not *worthy* of inclusion into the conversation of sexuality education and can perpetuate hostility and sexual prejudice that lead to physical and psychological harm for students who identify as LGBTQIA2S+.[17,35]

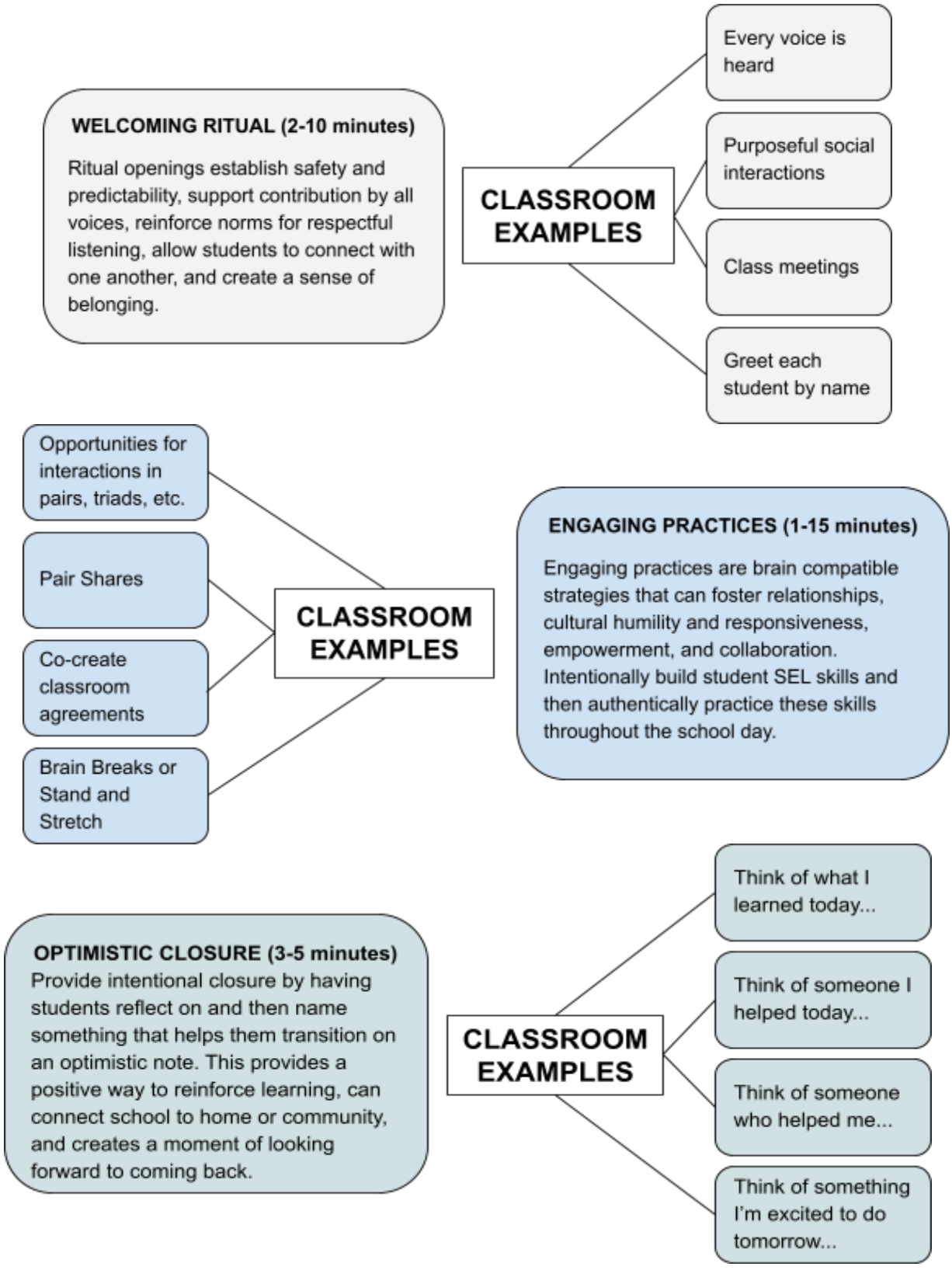
Ineffective, and strongly discouraged teaching strategies include fear-based tactics and shaming practices. Studies of abstinence-only programs, which often rely on fear and shame tactics, are harmful and ineffective in delaying students' engagement in sexual behaviors as well as

preventing unintended pregnancy and STIs.[18,42] It's also important that students are taught from a young age the medically accurate terminology for terms such as vulva, penis, scrotum, vagina, and more. Using medically accurate terminology for body parts helps remove the shame and stigma surrounding these words and can empower students who may be victims of child sexual abuse to speak out. In a similar fashion to Violence Prevention, it's also highly suggested that teachers and administrators become familiar and more comfortable with these terms c. Current discussions and topics within CSE are unlike what many administrators and teachers experienced in their youth and now are necessary to help prevent ACEs such as child sexual abuse (through discussions of bodily autonomy and consent) and interpersonal violence (through discussions of healthy and unhealthy relationships).

The following page has a quick snap-shot of how the skills align within the CSE unit for each grade level. For a more detailed understanding of the suggested materials, unit order, and lesson pacing, click here to access the Health at a Glance.

Diagram 1

Source: [Oakland Unified School District: Three Signature SEL Practice for the Classroom.]



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